Trent C. Holmberg, M.D.
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PATIENT INFORMATION

NAME: LAST	FIRST	MIDDLE	SUFFIX	BIRTHDATE:
STREET ADDRESS	CITY	STATE	ZIP CODE	
CELL PHONE:	HOME PHONE:	WORK PHONE:	EMAIL: **(do not provide if you do not wish to be contacted via email)**	

Please check all methods we may use to contact you: ☐ **No Preference** ☐ **Cell** ☐ **Home** ☐ **Work** ☐ **Email**

We usually call cell numbers first, but if unavailable we may call alternative numbers provided or email you unless specifically instructed not to. For specific instructions, please list below:

SEX: ☐ **MALE** ☐ **FEMALE** ☐ **OTHER** MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **SEPARATED** ☐ **WIDOWED**

KNOWN DRUG ALLERGIES & REACTIONS:

RESPONSIBLE PARTY INFORMATION

(This is the person who will be paying for visits. If you are over 18 please sign below.

RESPONSIBLE PARTY: (Stop here if self)	RELATIONSHIP TO PATIENT:	CELL PHONE:	EMAIL:
ADDRESS:	CITY:	STATE:	ZIP CODE:

I hereby give my written consent for the Office of Trent C. Holmberg, MD to discuss billing related issues with my responsible party and or receive receipts or statements which may contain some protected health information. _____ Check here if under 18

Signature of Patient (if over 18) ____ Date: ______________________________

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:	RELATIONSHIP TO PATIENT:	CELL PHONE:	EMAIL:

FINANCIAL AGREEMENT

I understand that this is a "FEE FOR SERVICE" practice and that payment in full is due at the time of service. I understand that Dr. Holmberg is not a provider for any insurance company and that it is my responsibility to find out how to submit claims to my insurance company for reimbursement. I understand that if I have an unpaid balance for over 120 days and Dr. Holmberg's office is unable to collect payment from me or my responsible party, Dr. Holmberg has the right to refer me to another provider. I understand that if I miss an appointment without giving any notice, I will be charged the full fee for that appointment. I understand that if I cancel less than 24 hours in advance, I will be charged a $75 cancellation fee. I further understand that I will be charged a $35.00 fee for any returned checks written and that my account will be placed on a "no checks" status for 1 year.

Signature: ____ **Date:**___________________________

SELF PAY PATIENTS HAVE THE RIGHT TO DENY THEIR HEALTH INSURANCE COMPANY ACCESS TO THEIR PATIENT HEALTH INFORMATION. **Some medications as well as mental health visits may require a prior authorization in order for your insurance company to pay for them. In order to complete a prior authorization, insurance companies may request treatment records or a letter of necessity which usually requires disclosure of sensitive personal health information. As a self-paying patient, you have the right to deny your insurance company access to those records unless you are submitting claims for reimbursement or expecting them to pay for a medication related to your treatment at this office. If you do not want your health insurance company to have access to your personal health information, please let us know so you can fill out the proper form. Otherwise please sign below.**

I authorize the office of Trent C. Holmberg, MD to release any personal health information necessary, including progress notes if necessary, to process claims or complete prior authorizations requested by my insurance company or a pharmacy.

Signature: ____ **Date:** __________________________

Patient Name: ____ Date of Birth: __________________________

PATIENT HEALTH QUESTIONNAIRE (PHQ)

Patient Name: ________________________ **Date of Birth:** ________________________
Physician: ________________________ **Date:** ________________________

Currently I am: ☐ **on medication for depression** ☐ **not on medication for depression** ☐ **in counseling**

Over the last 2 weeks, how often have you been Bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling/staying asleep, sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself - or that you are a failure or have let Your family down.	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television.	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way.	**0**	**1**	**2**	**3**

A. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

B. In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?
☐ **Yes** ☐ **No**

Anxiety Symptoms Rating Scale

Symptoms	Rating Scale: 0 = not at all 10 = couldn't be worse
Worries: **May include worries about personal safety, safety of others, safety of family, future, natural disasters, social acceptance, being liked, being abandoned, not being able to control what happens, bad things happening, little things that happen during the day.**	**0 1 2 3 4 5 6 7 8 9 10**
Fears: **May include the following symptoms: performance anxiety, avoids fear-inducing situations. May be fearful of: heights, social situations, separating from parent, being followed, being hurt by others.**	**0 1 2 3 4 5 6 7 8 9 10**
Panic symptoms (cardiovascular): **May include the following symptoms: increased heart rate, increased blood pressure, irregular breathing, getting lightheaded, chest pain/ pressure, feelings of not being able to get enough air into your lungs.**	**0 1 2 3 4 5 6 7 8 9 10**

Disability Scale*

Directions: Rate your current disability due to current symptoms of all medical and mental health conditions. 0 = n/a

Work: **the symptoms have disrupted your work**
0 1 2 3 4 5 6 7 8 9 10

Social Life: **the symptoms have disrupted your social life**
0 1 2 3 4 5 6 7 8 9 10

Family Life: **The symptoms have disrupted your family life/home responsibilities**
0 1 2 3 4 5 6 7 8 9 10

***Sheehan Disability Scale. Sheehan D.V., Harnett-Sheehan K. Raj B.A.**
The Measurement of Disability. International Clinical Psychopharmacology 1996, 11 (suppl 3): 89-95

Trent C. Holmberg, M.D.

Behavioral Health Personal History Questionnaire

This form will help your doctor to get the most complete picture of your background and present problems as well as make your evaluation as thorough as possible. If there is a question you cannot or do not wish to answer, please leave it blank.

Did someone refer you to Dr. Holmberg? ☐ Yes ☐ No If yes, by who? ________________________

Name of individual completing this form: ________________________

CURRENT PROBLEM(S)

Describe the problem(s) you are seeking treatment for:		Doctor Comments:
When did this/these problem(s) start?		
What do you think caused this/these problem(s)?		
Why are you seeking treatment now?		
What have you tried so far to help you solve your problem(s)?		
What goals do you hope to achieve by seeking treatment?		
List current mental health treatment. List provider name, specialty and date of last visit:		
Current Medications and Dosages:	Response or Side Effects	

Today's Date: Patient Name: Date of Birth:

Past Mental Health History

List any treatment or counseling you have had:

Provider/Type	Dates:	Was this helpful?
		Yes/No
		Yes/No
		Yes/No

Past Mental Health Medications Only	Response or Side Effects:

Did you suffer from mood problems before age 25? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If you answered yes, please methods and dates:

Have you had recent thoughts of hurting yourself or others? ☐ Yes ☐ No

Have you had any past mental health hospital stays? ☐ Yes ☐ No

Any drug and alcohol abuse treatment? ☐ Yes ☐ No

If you answered yes to either of the above, list location and dates:

Answer this section if you had or do have any drug or alcohol use: ☐ None

How many drinks (equal to one ounce of alcohol) do you have in a week?

Have you ever....

1. Consumed alcohol or used drugs more than you meant to in the past year?	☐ Yes ☐ No
2. Wanted to cut down on your drinking or drug use in the past year?	☐ Yes ☐ No
3. Been annoyed by others criticizing your drinking or drug use?	☐ Yes ☐ No
4. Felt guilty about your drinking or drug use?	☐ Yes ☐ No
5. Had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?	☐ Yes ☐ No

Circle if you have ever used:

Alcohol
Cocaine
Ecstasy
Heroin
Opiates/Oxycontin
Sedatives/Downers
Marijuana
Meth
Inhalants
Bath Salts
Hallucinogens
Other: ___________________________

Circle if you have ever had:

Alcohol-related seizures
Alcohol-related hallucinations
Alcohol-related blackouts
Severe alcohol withdrawal
Alcohol poisoning

Other severe alcohol or drug-related symptoms:

Doctor Comments:

Today's Date: Patient Name: DOB:

CHILDHOOD

During childhood or teenage years did you experience:

Mood Problems	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐
Hyperactivity	Yes ☐	No ☐
Poor Attention	Yes ☐	No ☐
Behavior Problems	Yes ☐	No ☐
Family Problems	Yes ☐	No ☐
Legal Problems	Yes ☐	No ☐
Running Away	Yes ☐	No ☐
Shyness	Yes ☐	No ☐
Difficulty in School	Yes ☐	No ☐
Drugs and Alcohol	Yes ☐	No ☐
Skipping School	Yes ☐	No ☐
Poor Grades	Yes ☐	No ☐
Problems with Math	Yes ☐	No ☐
Problems with Reading	Yes ☐	No ☐
Problems with Writing	Yes ☐	No ☐
Eating Disorder	Yes ☐	No ☐

Doctor Comments:

FAMILY HISTORY

Current Marital Status:

☐ Never Married ☐ Married ☐ Divorced ☐ Domestic Partner

Gender Identity:

☐ Female ☐ Male ☐ Transgender/Other ☐ Prefer not to answer

Sexual Orientation:

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Prefer to Not Answer

Children (living and deceased)	Age	Live at Home?	Relationship Good	Fair	Poor

Are there any specific problems with the children? If so, what?

Names of Parents/Step Parents	Living: Yes	No	Relationship: Good	Fair	Poor
Mother/Step Mother:					
Father/Step Father:					
Names of Siblings:					

FAMILY MENTAL HEALTH HISTORY

Has any blood relative had any of the following conditions:

Depression	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐
OCD	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Schizophrenia	Yes ☐	No ☐
Bipolar Disorder	Yes ☐	No ☐
Suicide	Yes ☐	No ☐
Alcohol/Drug Abuse	Yes ☐	No ☐
Developmental Disabilities	Yes ☐	No ☐
Dementia	Yes ☐	No ☐

Today's Date: Patient Name: DOB:

SOCIAL HISTORY	
Who do you live with (Spouse, Children, Roommates, etc.)?	Doctor Comments:
Where were you raised?	
Were you adopted and if so, at what age?	
Parents: Still Married ☐ Divorced ☐ If parents divorced how old were you?	
Highest Level of Education Completed and/or Degree:	
Were you abused as a child? Yes ☐ No ☐ If yes, how? Physically ☐ Mentally ☐ Verbally ☐ Neglect ☐ Other ☐ At what age/s?:	
List any other significant traumatic events you have experienced and at what age:	
Occupation/Employment: Employed ☐ Unemployed ☐ If employed, current employer: Position: For how long: Are you satisfied with current job? Yes ☐ No ☐ Stressful: Yes ☐ No ☐ Past Occupations:	
Sources of Income: Self ☐ Spouse ☐ Disability ☐ Alimony/Child Support ☐ Other ☐	
Financial Status: Adequate ☐ Significant Financial Stress ☐ Bankruptcy ☐	
Current Religion: Prefer not to answer ☐ Religion of family when growing up: Is religion or spirituality important in your life? Yes ☐ No ☐	
TALENTS AND STRENGTHS	
List three of your strengths: 1. 2. 3.	
How do you learn best? By doing ☐ By watching ☐ Be reading ☐ By listening ☐	
Hobbies or Leisure Activities: Are you participating in them now? Yes ☐ No ☐	
LEGAL HISTORY	
I do not have any legal history ☐	
Arrests ☐ Probations ☐ Convictions ☐ Parole ☐ DUI ☐ Assault ☐ List any pending court dates:	

Today's Date: Patient Name: DOB:

MEDICAL HISTORY

List of Allergies to Medications: No Known Drug Allergies ☐

Doctor Comments:

Primary Care Physician: Date of last Visit:

Do You Frequently Use:
Caffiene ☐ If so, daily amount:______ Tobacco ☐ Daily packs per day:________
Herbs ☐ Diet Aids ☐ Laxatives ☐ Cough Syrup ☐ Other ☐

Menstrual History (Femailes Only):

Check all that apply:

- ☐ Regular Menstrual Cycle
- ☐ PMS
- ☐ Irregular Menstrual Cycle
- ☐ Sexually Active
- ☐ Menstrual Pain
- ☐ Use Birth Cotrol
- ☐ Menopausal
- ☐ Pregnant. How many weeks ____

Medical Conditions:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Asthma
- ☐ Bone Fractures
- ☐ Cancer
- ☐ Chronic Constipation
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis/Irritable Bowel Syndrome
- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Disease
- ☐Heart Rhythm Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Loss of Consciousness
- ☐ Lupus
- ☐ Nausea/Vomiting
- ☐ Seizures
- ☐ Serious Injuries
- ☐ Sexual Dysfunction
- ☐ Sinus Infections
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Urinary Tract Infections
- ☐ Other Concerns about your Health

CHRONIC PAIN

Do you suffer from Chronic Pain? Yes ☐ No ☐ If yes, location:

Please rate your current pain: (Circle)
(none) 1-------2-------3-------4-------5-------6-------7-------8-------9------10 (worst ever)

Physician Treating Pain Condition:

SURGICAL HISTORY

Check all that apply and list approx. dates:

- ☐ Appendix
- ☐ Back
- ☐ Bladder
- ☐ Gall Bladder
- ☐ Heart (list type) _________
- ☐ Hysterectomy
- ☐ Neck
- ☐ Stomach Bypass
- ☐ Thyroid
- ☐ Tonsils
- ☐ Other (describe)

Today's Date: Patient Name: DOB:

SYMPTOM CHECKLIST

Please indicate how much you have experienced the following symptoms in the last 30 days.

Symptom	Not at all	A little	A lot	All the time	Doctor Comments:
1. Sad or Depressed					
2. Irritable					
3. Crying					
4. Feeling unworthy or like a failure					
5. Felling guilty					
6. Loss of interest in most things or that I used to enjoy					
7. Loss of pleasure in most things					
8. Lack of motivation					
9. Withdrawing or Isolating oneself					
10. Change in sexual desire					
11. Problems with memory					
12. Difficulty making decisions					
13. Difficulty concentrating					
14. Distracted					
15. Change in appetite					
16. Change in weight					
17. Tired or loss of energy					
18. Sleeping more than usual					
19. Difficulty falling asleep					
20. Difficulty staying asleep or waking too early					
21. Decreased need for sleep					
22. Feeling that there is no hope					
23. Thoughts of death or suicide					
24. Worrying or feeling anxious					
25. Feeling tense or stressed					
26. Panic attacks					
27. Restlessness					
28. Constant worries					
29. Headaches or other aches and pains					
30. Irrational fears or situations or objects					
31. Washing hands over and over					
32. Checking things repeatedly (stove, locks)					
33. Meaningless thoughts you cannot stop					
34. Feeling that you are unsafe					
35. Feeling that someone is monitoring you					
36. Feeling that someone is out to hurt you					
37. Unusual ideas or experiences which other people do not have					
38. Hearing voices that others do not hear					
39. Seeing things that others cannot see					
40. Feel that you have special powers					
41. Irresponsible risk-taking					
42. Period of very high energy					
43. Much better mood than usual					
44. Racing thoughts					

Today's Date: Patient Name: DOB:

MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on task?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Designed for screening purposes only and not to be used as a diagnostic tool. *Derived from Hirschfeld RM, Am J Psychiatry, 2000:157 (11):1873-5

Today's Date: Patient Name: DOB: